Eye MD's of Puget Sound
PEDIATRIC REGISTRATION

Patient Information: (please print) Date: _____/_____/_____

Last Name: _____ First: _____ Middle: _____ Sex: M / F

Home Address: _____ Home Phone: (_____)_____-_____

City: _____ State: _____ Zip: _____ Alternate Phone: (_____)_____-_____

Birthdate: _____ Age: _____ Social Security No.: _____

The following questions are being asked as a requirement for the Healthcare Reform Act and Meaningful Use. If you wish to not answer these questions please check "Decline to Answer."

Race:

- ☐ American Indian or Alaskan Native
- ☐ Native Hawaiian or Pacific Islander
- ☐ Black or African American
- ☐ Asian
- ☐ White
- ☐ Decline to Answer

Ethnicity:

- ☐ Not Hispanic or Latino
- ☐ Hispanic or Latino
- ☐ Decline to Answer

Parent/Guardian Information:

Last Name: _____ First: _____ Middle: _____ Birthdate: _____

Home Address: _____ Home Phone: (_____)_____-_____

City: _____ State: _____ Zip: _____ Alternate Phone: (_____)_____-_____

Relationship to Patient: _____ E-Mail: _____ Social Security No.: _____

In case of emergency please contact:

Name: _____ Phone: (_____)_____ Relationship:_____

Is it okay to release health information to this person? **Y / N**

Primary Care Doctor: _____ Phone: (_____)_____

Primary Pharmacy: _____ Phone: (_____)_____

Insurance Information:

Primary Insurance

Company: _____

Are you the subscriber? **Y / N**

If No, please fill out the name of insured information below

Name of Insured: _____

Insured D.O.B:_____

Insured relationship to patient: _____

Secondary Insurance

Company: _____

Are you the subscriber? **Y / N**

If No, please fill out the name of insured information below

Name of Insured: _____

Insured D.O.B: _____

Insured relationship to patient: _____

Health Questionnaire

Patient Name:_____ **Date of Birth:**_____

Reason for visit today:_____

Medical History (Current and Past)

Check ALL that apply

Ocular:
- ☐ Macular Degeneration
- ☐ Glaucoma
- ☐ Sjogren's Disease
- ☐ Cataracts

Constitution:
- ☐ Weight Changes
- ☐ Fatigue

Cardiovascular:
- ☐ Irregular Heartbeat
- ☐ Hypertension
- ☐ High Cholesterol
- ☐ Pacemaker

Gastrointestinal:
- ☐ Nausea/Vomiting
- ☐ Hepatitis: A, B or C

Genitourinary:
- ☐ Dialysis
- ☐ Kidney Failure
- ☐ UTI
- ☐ STD

Musculoskeletal:
- ☐ Arthritis
- ☐ Multiple Sclerosis

Respiratory:
- ☐ Asthma
- ☐ COPD

Psychological:
- ☐ Dementia
- ☐ Anxiety
- ☐ Depression

Neurological:
- ☐ Migraines
- ☐ Bell's Palsy
- ☐ Dizziness
- ☐ Stroke
- ☐ Seizures
- ☐ Epilepsy

Endocrine:
- ☐ Thyroid (high or low)
- ☐ Diabetic: type 1 or 2

  Last A1C:_____

Have you ever smoked?

☐ No ☐ Yes

if yes: year started:_____

year quit:_____

Any other illnesses not listed:_____

_____

Please list other specialist Doctors:_____

_____

Medication list: Please list all medications you currently take daily and reason for taking:

1. _____ 5._____
2. _____ 6._____
3. _____ 7._____
4. _____ 8._____

Allergies: Please list all medication allergies: _____

_____

_____

Past surgeries: _____

_____

_____

Family History

☐ Diabetes ☐ Macular Degeneration ☐ Glaucoma ☐ Cancer

Eye MDs of Puget Sound
Patient Treatment Agreement

Consent to Treat:
I request and authorize Eye MDs of Puget Sound to examine and treat me (or my minor child). I agree to ask for information about any exam or procedure and when I am satisfied that I fully understand the benefits and risks for the proposed exam/procedure, I further authorize and request that such exam/procedure be performed.

Services:
We are medical physicians specializing in ophthalmology. If we treat medical or surgical conditions pertaining to your eyes, we bill your **MEDICAL** insurance for that treatment. These services are paid under your insurance plan, less the co pays and deductibles you are personally responsible for.

Refractions are necessary to determine your glasses prescription and the charge is rarely covered by insurance companies. Refractions may even be necessary for medical purposes, whether or not you need a new glasses prescription. We expect payment for refractions at time of service. The refraction fee is currently $49.00. INT_____

Financial:
Our office will bill contracted primary and secondary MEDICAL insurance companies. If you have a non-contracted insurance, please ask for a copy of your bill and be prepared to pay at time of service. **We do not contract with VISION insurances. It is your responsibility to know if your insurance plans cover your visit with us. INT_____**

Co-payments required by your insurance are to be paid at the time of service. If the co-pay and refraction charge is not paid at the time of service there will be a $5.00 billing fee. There will be a finance charge assessed to all patient balances not paid within 30 days. INT____

It is your responsibility to obtain a referral for your visit if your insurance company requires one prior to visiting with our doctor. Your failure to do so may result in your appointment being rescheduled, or the charges being your full responsibility. Our office does not call for referrals.

The responsibility for payment of your account remains with you at all times even though you may have an insurance claim or legal matter pending. This office does not accept responsibility for negotiating a settlement on a disputed claim.

Authorization and Release of Medical Information:
I authorize Eye M.D.s of Puget Sound to provide information with regard to my diagnosis and treatment to my insurance company if they request such information to pay my bill. I also direct my insurance company to pay all insurance benefits directly to Eye M.D.s of Puget Sound.

Signature indicates clear understanding and acknowledgement of the agreement.

Signature _____

Date_____

EYE M.D.S OF PUGET SOUND, PLLC

ACKNOWLEDGEMENT OF RECEIPT/OFFER

OF NOTICE OF PRIVACY PRACTICES (Attachment 9)

Dear Patient:

Federal law requires us to provide you with a Notice of Privacy Practices, which is our explanation of how we use and disclose your health information, and to ask you to acknowledge that you have received the Notice.

You have the right to review our notice before signing this acknowledgement, and if you have any questions, to ask for an explanation of any part of the Notice, or any other aspects of our use and disclose of your health information. The terms of our Notice may change as the law and our practices change. If we change our Notice, we will have revised copies available to you when you visit us.

We appreciate your signing this form, which acknowledges that you have received, or have been offered and refused, a copy of our Notice.

Patient Name_____

Patient/Representative Signature_____

Date_____